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Key Themes in Section 1115 Medicaid Expansion Waivers

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Seven states currently are implementing the Affordable Care Act's (ACA) Medicaid expansion to nearly all low income adults up to 138% of the federal poverty level (FPL, $16,643 per year for an individual in 2017) in ways that extend beyond the flexibility provided by the law through a Section 1115 demonstration waiver approved by the Obama Administration. While Congress debates repeal and replacement of the ACA, including the Medicaid expansion, Section 1115 Medicaid expansion waiver activity is expected to continue under the Trump Administration with waiver amendments, extensions, and new waivers that may change the terms of traditional expansions or implement new expansions. Section 1115 waivers can be used for a variety of purposes. This issue brief focuses on Section 1115 waivers that implement the ACA's Medicaid expansion and highlights themes in approved, pending, and denied provisions to date as well as key issues to watch looking ahead. Additional detail about each state's waiver is provided in the Appendix tables.

Key Takeaways

- **What waiver provisions have been approved?** Common themes in the seven Medicaid expansion waivers approved to date in Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire include using Medicaid as premium assistance; charging premiums above federal limits; eliminating non-emergency medical transportation; and offering healthy behavior incentives to reduce premiums and/or co-payments. Additional provisions approved in Indiana include making coverage effective with the first premium payment instead of on the application date; eliminating retroactive eligibility (later approved in New Hampshire and Arkansas); and barring certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums (later approved for three months in Montana).
- **What waiver provisions have been denied?** Under the prior Administration, CMS denied Medicaid expansion waiver provisions that would have reduced coverage; required premiums for beneficiaries with incomes under 100% FPL as a condition of eligibility; waived Early and Periodic Screening, Diagnostic, and Treatment benefits for children and beneficiaries' free choice of family planning provider; and imposed work requirements as a condition of eligibility. To date, CMS also has required states to cover all expansion adults up to 138% FPL to receive enhanced federal matching funds.
- **What issues should we watch?** As the new Administration considers waiver requests, including those currently pending for Kentucky and Indiana, areas to watch include provisions that reduce coverage under existing expansions; seek enhanced federal matching funds for partial coverage expansions; require work as a condition of eligibility; or impose lifetime limits. Other key areas to watch are the application of federal budget neutrality requirements and the waiver transparency rules and consideration of waiver evaluation results when determining whether certain provisions are approved in other states.

Introduction

The ACA's Medicaid expansion changes the role of Section 1115 waivers for coverage expansions, eliminating the need for a state to obtain a waiver to cover childless adults and providing significant federal funding (100% from 2014 through 2016, gradually decreasing to 95% in 2017, and 90% by 2020) for states to expand coverage. Prior to the ACA, a number of states used Section 1115 waivers to expand coverage to childless adults who then could not otherwise be covered under federal rules. Because Section 1115 waivers must be budget neutral for federal spending, according to long-standing federal policy, states could not receive additional federal funds to expand coverage to these adults and, as such, needed to redirect existing federal funds or find offsetting program savings to finance this coverage. The ACA eliminates the historic exclusion of adults without dependent children from Medicaid, enabling states to expand coverage without a waiver and with enhanced federal matching funds. As of March, 2017, 32 states including DC have adopted the expansion, with most implementing traditional expansions as set forth by the law, and seven states using Section 1115 waivers to implement in ways not otherwise permitted under federal law.

Key Waiver Policy Findings

Approved ACA Expansion Waivers

As of March, 2017, seven states (Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire) have approved Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the law. Some states sought waiver authority as a politically viable way to expand coverage and receive enhanced federal matching funds. Nearly all of these waivers are limited to provisions related to the Medicaid expansion; these waivers were the mechanisms by which these states first implemented their expansions. The exception is Arizona, which has a long-standing Section 1115 waiver that governs its entire Medicaid program, and which initially implemented a traditional expansion but subsequently obtained waiver authority to alter the terms of that expansion in ways not otherwise permitted under existing law.

While each expansion waiver is unique, they include some common provisions, such as implementing the Medicaid expansion through a premium assistance model; charging premiums beyond what is authorized in federal law; eliminating non-emergency medical transportation, an otherwise required benefit; and using healthy behavior incentives to reduce premiums and/or co-payments (Table 1). Indiana's waiver includes provisions that had not been approved in other states, such as making coverage effective on the date of the first premium payment instead of the date of application; barring certain expansion adults from re-enrolling in coverage for six months if they are dis-enrolled for unpaid premiums (a three-month lock-out was later approved in Montana); and eliminating retroactive eligibility (later approved in New Hampshire and Arkansas). The retroactive eligibility waivers were conditional, requiring states to implement safeguards to protect beneficiaries from unpaid medical costs incurred just prior to Medicaid eligibility. For example, Indiana expanded its presumptive eligibility program and implemented a prior claims payment program to cover retroactive costs for the mandatory (non-expansion) parents and 19 and 20 year olds covered under its waiver. Arkansas and New Hampshire were required to ensure that eligibility determinations are timely and without gaps in coverage.

Table 1: Themes in Approved ACA Expansion Waivers as of March, 2017							
	AR	AZ	IA	IN	MI	MT	NH
Premium Assistance	QHP & ESI		ESI	ESI	QHP[iv]		QHP
Premiums / Monthly Contributions	X	X	X	X	X	X	
Healthy Behavior Incentives		X	X	X	X		
Waive Required Benefits (NEMT)	[i]		X	X			
Waive Reasonable Promptness				X			
Waive Retroactive Eligibility	X[ii]			X			X[v]
Co-payments Above Statutory Limits				X[iii]			
12-Month Continuous Eligibility						X	

NOTES: QHP = Qualified Health Plans. ESI = employer-sponsored health insurance. NEMT = non-emergency medical transportation. [i] AR waiver provides authority for state to not offer NEMT for individuals covered through ESI who do not demonstrate need for services. [ii] AR's retroactive coverage waiver is contingent upon the state meeting standards for timely eligibility determinations, offering a reasonable opportunity period for immigration status verifications, and implementing a presumptive eligibility program. [iii] IN's cost-sharing waiver was approved under Section 1916 (f), not Section 1115. [iv] MI's premium assistance authority is effective in April, 2018. [v] NH's retroactive coverage waiver is contingent upon state submission of data showing no gaps in coverage.

Denied ACA Expansion Waivers or Waiver Provisions

The previous Administration denied some specific provisions included in states' Medicaid expansion waiver proposals, including premiums for beneficiaries with incomes under 100% FPL as a condition of eligibility; elimination of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits and beneficiaries' free choice of family planning provider; and work requirements as a condition of eligibility. The previous Administration also denied Ohio's waiver application, noting that Ohio had implemented a successful traditional ACA expansion and estimated that its proposed policy changes "would lead to over 125,000 people losing coverage each year" compared to the current expansion. CMS also issued policy guidance, consistent with its legal interpretation of the ACA, indicating that states cannot receive enhanced federal ACA expansion funding unless they cover all newly eligible adults through 138% FPL.

Pending ACA Expansion Waivers

Two states currently have Medicaid expansion waivers pending before the Centers for Medicare and Medicaid Services (CMS). Indiana proposes to extend its current Medicaid expansion waiver from 2018 through 2021, with some changes, such as a three-month coverage lock-out for beneficiaries who do not timely renew eligibility, a 1% premium surcharge for tobacco users beginning in the second year of enrollment, and outcome-based healthy behavior incentives related to tobacco cessation, substance use disorder treatment, chronic disease management, and employment (see Appendix Table 3). Kentucky is awaiting a decision on its waiver application that seeks changes to its traditional expansion, such as sliding scale premiums, requiring premium payment before coverage is effective, locking those above 100% FPL out of coverage for six months for premium non-payment, requiring work as a condition of eligibility for most adults, locking beneficiaries out of coverage for six months for failure to timely renew eligibility, adding a high deductible health savings account, offering a healthy behavior incentive account, and waiving NEMT (see Appendix Table 5).

Two other states are preparing waiver submissions to CMS. Arizona recently completed a state public comment period for a waiver amendment that proposes changes to coverage for all "able-bodied" Medicaid adults, not only those who newly gained coverage under the ACA's expansion, including a work requirement as a condition of eligibility, a 5-year lifetime limit on benefits, monthly income and work verifications and eligibility renewals, and a one-year lock-out for those who knowingly fail to report a change in income or make a false statement about work compliance. Arizona previously sought similar changes, which were denied by the Obama Administration in September, 2016, but state law requires Arizona to request these components annually. Additionally, Arkansas announced that it will seek waiver amendments, such as reducing Medicaid eligibility for expansion adults from 138% to 100% FPL while continuing to receive enhanced federal matching funds and establishing a work requirement.

Other Waiver Parameters

Certain requirements apply to all Section 1115 waivers, not just those that authorize Medicaid expansions. While not required by statute or regulation, CMS has a longstanding policy that waiver financing must be budget neutral for the federal government, meaning that federal costs under a waiver must not exceed what federal costs would have been for that state without the waiver. Budget neutrality is enforced by establishing a cap on federal funds under the waiver, putting the state at risk for any costs beyond the cap. The ACA also established new rules about transparency and evaluations for all waivers. Recognizing that waivers can authorize changes that impact beneficiaries, providers, health plans, and other stakeholders in important ways, the waiver transparency rules require state and federal public comment periods before all new waiver applications and extensions of existing waivers are approved by CMS. (The rules do not require notice and comment for waiver amendments, but to date, CMS has applied these requirements to waiver amendments.) In keeping with statutory requirement that Section 1115 waivers test new program approaches, the evaluation rules require states to have a publicly available, approved evaluation strategy and to submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes.

Looking Ahead

State interest in Medicaid expansion waivers as a way to gain flexibility to adapt their programs is likely to continue under the Trump Administration. States, beneficiaries, providers, and other stakeholders will be interested in learning how the new Administration will respond to Medicaid expansion waiver requests, especially those that contain provisions that could lead to less people enrolled in coverage compared to existing expansions. It also remains to be seen whether legal interpretations and guideposts established by the prior Administration, such as not permitting states to access enhanced federal matching funds for partial coverage expansions, will continue to be observed. Decisions on proposals that have not previously been approved under Medicaid, such as whether states could condition Medicaid eligibility on work or set a lifetime coverage limit, also will be key markers for future waiver policy. In addition to states' substantive waiver requests, stakeholders will be interested in the new Administration's approach to the waiver process, including the application of federal budget neutrality requirements and the transparency rules and the role that waiver evaluations will play in determining whether certain provisions are approved in other states. While Congress debates fundamental changes to the Medicaid program's structure and financing and considers ACA repeal, Medicaid policy changes authorized through Section 1115 waivers will be a key area to watch.

Appendix

Appendix Table 1: Provisions Affecting Medicaid Expansion Adults in Arizona's Section 1115 Medicaid Expansion Demonstration Waiver

Appendix Table 2: Arkansas' Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 3: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 4: Iowa's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 5: Kentucky's Proposed Section 1115 Medicaid Expansion Demonstration Waiver

Appendix Table 6: Michigan's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 7: Montana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 8: New Hampshire's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Appendix Table 1: Provisions Affecting Medicaid Expansion Adults in Arizona's Section 1115 Medicaid Expansion Demonstration Waiver[i]	
Element	**Arizona Waiver Provision**
Overview[ii]:	Changes Medicaid coverage for the ACA expansion population from 100-138% FPL from the traditional ACA expansion to the CARE Program, which imposes premiums of 2% of income; imposes co-payments up to 3% of income paid monthly into health savings accounts; and creates a healthy behavior incentive program.
Duration:	1/1/17 through 9/30/21
Coverage Groups:	Newly eligible parents and childless adults from 100-138% FPL.
Exempt Populations:	American Indian/Alaska Natives, people with serious mental illness, and people who are medically frail are exempt from participation. Participation is voluntary for exempt groups and newly eligible adults at or below 100% FPL. These beneficiaries may fund a health savings account (described below), with the amount and timing of contributions at their discretion. No other program requirements apply. For mandatory participants, hardship exemptions are available for each month that beneficiaries meet one of the following criteria during the prior month: death in the household or household has a qualifying expense (health care expense, home repair, or transportation repair) that exceeds 10% of countable gross income.
Premiums:	Requires premiums of 2% of income or $25/month, whichever is less, paid into health savings account (described below).
Co-Payments:	Requires co-payments for certain services up to 3% of monthly or quarterly household income. Co-payments are paid into health savings account (described below) monthly for services already used, based on prior 6 months of service use, instead of at point of service. Co-payments are at state plan amounts for the following services: -$4 for opioid prescriptions, except for cancer patients, those in hospice, and those for whom physician requests exemption as medically necessary -$4 for brand name drugs when generic available, unless physician determines generic not as effective -$5 or $10 for specialist visits without PCP referral -$8 for non-emergency use of ER Premiums and co-payments are limited to 5% of quarterly household income.
Disenrollment for Non-Payment:	Beneficiaries above 100% FPL may be disenrolled for nonpayment of premiums (after two-month grace period) but there is no lock-out period. Beneficiaries disenrolled for nonpayment may re-enroll at any time without paying past-due amounts. Beneficiaries who re-enroll within 90 days do not need to re-apply. State may attempt to collect unpaid premiums but cannot report debt to credit agencies, place lien on beneficiary's home, refer to debt collectors, file a lawsuit or garnish wages.
Health Savings Accounts:	Health savings account funds may be used for health care related items on a list approved by CMS (with protocols that must be approved by CMS) if beneficiary pays premiums and co-payments timely and meets one healthy behavior target (described below). Third parties such as employers, providers, or charitable organizations may make health savings account contributions for beneficiaries. Any remaining account balance will be returned to beneficiaries who are no longer eligible for the demonstration.

Appendix Table 1: Provisions Affecting Medicaid Expansion Adults in Arizona's Section 1115 Medicaid Expansion Demonstration Waiver[i]	
Element	**Arizona Waiver Provision**
Healthy Behavior Incentives:	If beneficiaries self-attest to meeting one healthy behavior target, they may use their health savings account funds to pay for approved health care related services as described above. They also have the option to reduce their health savings account payments (excusing them from premium and co-payment liabilities for six months) or to roll unused health savings account funds over into the next year. Healthy behavior targets include preventive health targets (annual well exam, flu shot, mammogram, or glucose screening) and chronic disease management targets (tobacco cessation, diabetes management, asthma management, or substance use disorder management). State will provide education about healthy behavior program to beneficiaries.
Delivery System and Benefits:	Mandatory Medicaid MCO enrollment (no changes from AZ's existing Section 1115 waiver).
Status:	State must submit draft operational protocol to CMS for review and approval at least 90 days before planned CARE implementation. Protocol must cover contributions, accounts, and payment infrastructure as well as Healthy Arizona targets.
SOURCE: Ariz. Health Care Cost Containment System, Special Terms and Conditions, #11-W-00275/9, 21-W-00064/9, approved Oct. 1, 2016-Sept. 30, 2012, amended, Jan. 18, 2017.	

NOTES: i- Arizona's Section 1115 waiver (Arizona Health Care Cost Containment System (AHCCCS)) is much broader than the implementation of alternative ACA expansion model. Other waiver initiatives include (but are not limited to): Targeted Investments Program, to support physical and behavioral health integration for beneficiaries with behavioral health care needs; medical homes serving American Indians; and a Safety Net Care Pool to help defray the cost of uncompensated hospital care.
ii- The Arizona state legislature passed legislation in 2015 that requires AHCCCS to request amendments to the current Section 1115 waiver annually to allow for the implementation of work requirements, additional verification requirements, and a time limit on coverage for AHCCCS beneficiaries.

Appendix Table 2: Arkansas' Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Arkansas Waiver Provision (approved, as amended)**
Overview:	Uses Medicaid funds to pay Marketplace QHP or employer sponsored health insurance (ESI) premiums for all newly eligible adults statewide (estimated 200,000) under the ACA's Medicaid expansion. Waiver extension terminates health savings account program and establishes monthly premiums of up to 2% of household income for newly eligible beneficiaries from 100-138% FPL and a mandatory small group ESI premium assistance program. The extension includes additional waiver of retroactive coverage.
Duration:	9/27/13 to 12/31/21 Eligibility effective 1/1/14
Coverage Groups:	Newly eligible parents ages 19-64 between 17-138% FPL, and newly eligible adults without dependent children ages 19-64 between 0-138% FPL.
Exempt Populations:	People who are medically frail are exempt from QHP premium assistance and have choice of FFS coverage of same benefit package offered to new adult group or a benefit package that includes Medicaid state plan benefits. Medically frail individuals age 21 and over who have access to cost-effective ESI through a participating employer may choose to enroll in ESI with Medicaid premium assistance. ESI premium assistance enrollees may be disenrolled if they are determined medically frail after they are enrolled. American Indian/Alaska Natives are exempt from QHP or ESI premium assistance enrollment.
Enrollment, QHP Choice and Auto-Assignment:	Extension requires beneficiaries age 21 and over with access to cost-effective ESI through participating small group employers (2-50 employees) to participate in ESI.[i] All other beneficiaries must enroll in a Marketplace QHP with choice of at least 2 silver level plans covering only essential health benefits. If beneficiaries do not choose a plan, they will be automatically assigned to one based on target minimum market share of demonstration beneficiaries in each QHP in region. Beneficiaries have 30 days to change QHP after auto-assignment and FFS coverage prior to QHP or ESI enrollment.
Retroactive Coverage:	Under extension, three-month retroactive coverage is conditionally waived, after state completes eligibility determination mitigation plan and contingent upon timely eligibility determinations, provision of benefits during reasonable opportunity period for otherwise eligible individuals who attest to immigration status, and April 1, 2017 implementation of hospital presumptive eligibility program.
Premiums:	State pays monthly premiums directly to QHPs. For ESI, employer must pay 25% of overall cost of coverage, except that state pays employer share for 3 years for those who offer non-grandfathered coverage as of Jan. 2017, and had not offered any coverage in 2016 or previously offered only grandfathered coverage. Extension requires beneficiaries with income from 100-138% FPL are required to pay monthly premiums of up to 2% of household income, regardless of whether coverage is obtained through ESI or QHP. Premium payments are not a condition of Medicaid eligibility. State may attempt to collect unpaid premiums if beneficiaries do not make payments within two-month grace period but may not report debt to credit reporting agencies, place a lien on beneficiary's home, refer to debt collectors, file lawsuit, seek a court order to garnish earnings, or sell debt to a third party collection agency.
Cost-Sharing:	No cost-sharing for beneficiaries at or below 100% FPL. Extension requires beneficiaries from 100-138% FPL are responsible for Medicaid state plan level co-payments and co-insurance at the point of service, regardless of whether coverage is obtained through ESI or QHP. Providers can deny services for failure to pay cost-sharing. Medically frail > 21 are only subject to cost-sharing if they are enrolled in an ABP or ESI. Premiums and cost-sharing limited to 5% of monthly or quarterly income for both QHP and ESI beneficiaries.

Appendix Table 2: Arkansas' Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Arkansas Waiver Provision (approved, as amended)**
Benefits:	
QHP and ESI benefit packages:	QHPs and ESI plans provide services in the state's Medicaid Alternative Benefits Package (ABP) for newly eligible adults. ABP is the same as Medicaid state plan benefits package.
Federally qualified and rural health centers (FQHC/RHC):	QHP beneficiaries will have access to at least 1 QHP that contracts with at least one FQHC/RHC. ESI beneficiaries will have access to at least one FQHC/RHC through their ESI. If their ESI does not contract with an FQHC and RHC, beneficiaries may access through FFS.
Prescription drugs:	Limited to the QHP formulary. Prior authorization within 72 hours instead of 24 hours.
Family planning providers:	State covers QHP/ESI out-of-network family planning providers on FFS basis.
Wrap-around benefits:	Non-emergency medical transportation (NEMT) and EPSDT for 19 and 20 year olds provided FFS, except that state will not offer NEMT to individuals covered through ESI who do not demonstrate a need for such services.
Incentive benefit:	Subject to CMS approval of a waiver amendment and state protocol, state will offer an unspecified additional benefit not otherwise provided in the ABP for all beneficiaries at or below 100% FPL and for those from 100-138% FPL who pay premiums timely and "engage with a primary care provider."
Appeals:	Demonstration enrollees use the state fair hearing process for all appeals. (AR has approved SPA delegating Medicaid fair hearings for medical necessity and coverage issues for the new adults in QHPs to state department of insurance.[ii] Similar process to be used for those in ESI.)
Cost-Effectiveness:	May use state-developed tests of cost-effectiveness for premium assistance that differ from those otherwise permissible.
Oversight:	State Medicaid agency and state insurance department will enter into MOU or agreement with QHPs regarding enrollment, payment of premiums and cost-sharing reductions, reporting and data requirements, notices, and audits. State will require its vendor to enter into MOU with employers participating in the ESI premium assistance program.
Status:	Demonstration approved 9/27/13, first amendment approved 12/31/14, extension/second amendment approved 12/7/16. State to submit operational protocol for ESI premium assistance program by April 30, 2017.
SOURCE: Ark. Works, Special Terms and Conditions, #11-W-00287/6, approved Jan. 1, 2017-Dec. 31, 2021.	

NOTES: i- Additional protocols must be submitted by April 30, 2017 with details on how enrollment and disenrollment in Arkansas Works.
ii- Ark. State Plan Amendment #13-0013 MM4 (July 15, 2014), available at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-13-0013-MM4.pdf.

Appendix Table 3: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved, with pending extension request**
Overview:	Implements the ACA's Medicaid expansion by requiring most newly eligible adults with incomes from 0-138% FPL to pay monthly premiums by contributing to a Personal Wellness and Responsibility (POWER) health account. Newly eligible adults who pay premiums are eligible for HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period are disenrolled from coverage and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay premiums after a 60-day period receive HIP Basic, a more limited benefit package with state plan level co-payments. Also allows non-expansion parent/caretakers to pay premiums in lieu of co-payments for state plan services and offers optional Medicaid premium assistance for employer-sponsored insurance (ESI) for newly eligible adults over age 21. *Pending extension seeks to impose a three-month coverage lock-out for beneficiaries who do not timely complete the eligibility renewal process, a 1% premium surcharge for tobacco users beginning in the second year of enrollment, and require MCOs to implement additional outcome-based healthy behavior incentives related to tobacco cessation, substance use disorder treatment, chronic disease management, and employment.*
Duration:	2/1/15 to 1/31/18; seeking extension through 1/31/21
Coverage Groups:	Covers adults ages 19-64 with incomes from 0-138% FPL, including non-expansion (§ 1931) parent/caretakers, those eligible for Transitional Medical Assistance (formerly eligible as § 1931parent/caretakers), and adults newly eligible through the ACA's Medicaid expansion (approximately 350,000 beneficiaries statewide). *Pending extension request seeks to require HIP 2.0 enrollment for pregnant women up to 138% FPL (health plans, benefits, and cost-sharing for this population would be the same as in the state's traditional Medicaid program).* Excludes children, seniors, and dual eligible beneficiaries. American Indian/Alaska Natives may opt out of the demonstration 30 days after enrollment. Newly eligible AI/ANs who remain in the demonstration have the more generous (HIP Plus) benefit package, with coverage effective on the date of application, and no premiums or co-payments.
Coverage Effective Date:	Waives reasonable promptness so that HIP Plus coverage begins on the first day of the month in which a beneficiary makes an initial premium payment instead of the date on which beneficiary is determined eligible for Medicaid (retroactive to the application date). Beneficiaries have 60 days from the date of their eligibility determination to make this payment. However, individuals determined presumptively eligible (described below) will maintain presumptive Medicaid coverage for at least 60 days, and those found presumptively eligible who are subsequently determined fully eligible will have no gap in coverage. For those at or below 100% FPL, HIP Basic coverage begins on the first day of the month in which the 60-day premium payment period expires. Once in HIP Basic, beneficiary cannot move to HIP Plus until eligibility renewal, receipt of rollover funds (described below) or at other times designated by the state. *Pending extension request would enroll those at or below 100% FPL who move from another Medicaid coverage group into HIP Basic immediately, without waiting for expiration of 60-day payment period, although these beneficiaries would have 60 days after HIP Basic enrollment to choose to pay a premium and enroll in HIP Plus.*
Fast Track Payments:	Effective April 1, 2015, state allows for an optional $10.00 fast track initial POWER account pre-payment that makes enrollment effective the first day of the month in which payment is received, once a beneficiary is determined eligible. However, the beneficiary cannot change MCOs for a year after making a fast track payment. The fast track payment is refundable if the applicant is determined ineligible. If the beneficiary's regular monthly premium is less than $10.00, the MCO shall credit the remaining portion of the fast track payment to subsequent premium payments. If the beneficiary's regular monthly premium is more than $10.00, the beneficiary will be billed the difference on the next POWER account invoice.
Presumptive Eligibility:	State shall include FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant is financially and categorically eligible for Medicaid, while the final eligibility determination is pending with the state Medicaid agency.

Appendix Table 3: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved, with pending extension request**
	To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications), beginning January 2016. If the state fails to meet this standard, the reasonable promptness waiver will be suspended for the next 6 months. The state shall propose the standard based on the first 9 months of the demonstration.
Retroactive Coverage Transition Program:	Waives retroactive coverage of services incurred during the 90 days prior to Medicaid eligibility. However, for one year, the state will reimburse providers for services received up to 90 days prior to the effective Medicaid coverage date for non-expansion parent/caretaker relatives who were not determined presumptively eligible. If CMS determines that these beneficiaries are incurring costs that would have been reimbursed by Medicaid without the retroactive eligibility waiver (based on data provided by the state by Nov. 1, 2015), this transition program shall continue for the remainder of the demonstration. *Pending extension request seeks to eliminate the transitional prior claims payment program (described above).*
Lock-Out for Noncompliance with Renewals:	*Pending extension request seeks to prevent expansion beneficiaries who do not complete eligibility renewal process from re-enrolling in coverage. Those who are disenrolled for failing to verify eligibility at renewal can re-enroll without a new application if they provide verification within 90 days of disenrollment. After 90 days of disenrollment, they would have to wait another 3 months before re-enrolling. This policy would not apply to those who are medically frail, pregnant, non-expansion parents and 19 and 20 year olds, and those who experience a qualifying event that prevented completion of the renewal process (obtained and subsequently lost private coverage, lost income after disqualification due to increased income, moved to another state and then returned, domestic violence victim, residing in disaster area in 60 days prior to disenrollment).*
Delivery System and Health Savings Accounts:	Services provided by MCOs. MCOs also must bill and collect premiums from beneficiaries. POWER accounts are jointly funded by beneficiary premiums and the state. POWER account funds are used to fund the first $2,500 of covered claims, except for preventive services required by 42 USC § 300gg-13,[i] the cost of which are not charged against POWER account funds. Other preventive services are covered, subject to a $500 annual cap, and are charged against POWER account funds. State pays capitated rate to MCOs for services after the $2,500 POWER account funds are exhausted. Within 30 days after demonstration approval, the state must submit an operational protocol to describe the process for collecting POWER account contributions.
Beneficiary Premiums:	Monthly premiums apply to all beneficiaries from 0-138% FPL and are the greater of 2% of income (up to $28 per month for an individual at 138% FPL in 2017) or $1.00. Premiums for those at or below 5% FPL ($50 per month for an individual in 2017) will be $1.00/month. Premiums are a condition of eligibility only for non-medically frail beneficiaries from 101-138% FPL. *Pending extension request proposes charging higher premiums, at 3% of income, for tobacco users beginning in the second year of enrollment.* Cost-sharing (both premiums and co-payments) limited to 5% of quarterly household income. POWER account contributions cannot exceed 2% of household income (although each beneficiary will have their own POWER account). Beneficiary premium amounts are adjusted at annual renewal and anytime the state is made aware of an income change during the current coverage period. Beneficiary premiums shall be reduced by any POWER account contributions made by third parties, such as employers or non-profit organizations.
State Contributions:	The state funds the difference between the beneficiary's monthly premiums and the full $2,500 POWER account value. The state will make an initial $1,300 account contribution upon the beneficiary's MCO enrollment, and any additional amount owed by the state to the MCO for services provided to the beneficiary shall be reconciled after 12 months.

Appendix Table 3: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved, with pending extension request**
Consequences of Premium Non-Payment:	Newly eligible adults from 101-138% FPL who do not make a premium payment within a 60-day grace period are disenrolled from coverage and locked out for six months. Prior to disenrollment, the state shall review all other bases of Medicaid eligibility and notify the beneficiary about the option to request a medical frailty determination, and the MCO must provide 2 written notices about the delinquent payment. Beneficiaries who are disenrolled for non-payment of premiums are not subject to the lock-out if they re-apply with verification of non-payment due to a "qualifying event," such as moving to another state and then returning, experiencing domestic violence, or medical frailty.[ii] Individuals who never make their initial premium payment are not subject to the 6 month lock-out. Newly eligible adults from 101-138% FPL who are medically frail who do not pay premiums are not terminated from coverage. Instead, these beneficiaries must continue to have access to the state plan benefit package,[iii] are subject to state plan co-payments for services, and continue to be billed for premiums. Newly eligible adults at or below 100% FPL who do not make an initial premium payment within 60 days of their eligibility determination or who do not make a subsequent premium payment within the 60-day grace period are automatically enrolled in the HIP Basic plan. These beneficiaries will be subject to state plan co-payments for services, which may exceed the cost of monthly premiums applicable under HIP Plus. Non-expansion parent/caretakers and newly eligible adults at or below 100% FPL who are medically frail who do not pay premiums retain their existing benefit package (described below) and are subject to state plan co-payments.
Debts/Refunds Upon Disenrollment:	Payment of unpaid premiums is not a condition of Medicaid re-enrollment but may be owed as a debt.[iv] MCOs may attempt to collect unpaid premiums from beneficiaries but may not report debt to collection agencies, place a lien on beneficiary's home, refer cases to debt collectors, file a lawsuit, seek a court order to garnish wages, or sell the debt to a third party for collection. If beneficiaries have paid excess premiums,[v] they are owed a refund, subject to a 25% penalty if the beneficiary is terminated for non-payment of premiums.
Healthy Behavior Incentives:	HIP Plus beneficiaries who make timely premium payments will be eligible to rollover their share of the unused POWER account balance at the end of 12 months. If the beneficiary completes age and gender appropriate preventive services, the rollover balance for HIP Plus beneficiaries will be doubled by the state, not to exceed the beneficiary's total premium payments for the year. HIP Basic beneficiaries can rollover unused POWER account funds, up to 50% of the amount of premiums required for HIP Plus, if they obtained unspecified age and gender appropriate preventive services. Rollover funds can be used to reduce the required beneficiary premiums in the subsequent year. Debts may be collected from rollover account balances. *Pending extension seeks to require MCOs to implement HIP healthy behavior incentive initiatives targeting the following areas: tobacco cessation, substance use disorder treatment, chronic disease management (diabetes, weight management, pharmacy compliance), and employment (including completion of job training, work search, or educational activities through Gateway to Work program). The initiatives would provide incentives not only for program enrollment but also for completion of specified outcome milestones and targets. State would like to increase MCO incentive limit currently in place to $200 per initiative and $300 per member per year. State also will increase beneficiary and provider education about coverage of tobacco cessation services.*
Co-Payments for Non-Emergency Use of the ER:	All demonstration beneficiaries must pay a co-payment for non-emergency use of the ER, which is waived if the beneficiary calls the MCO's 24-hour nurse hotline prior to using the ER. These co-payments must be refunded if the beneficiary has an emergency condition or is admitted to the hospital on the same day. Grants § 1916(f) waiver authority for two-year demonstration (until Jan. 31, 2018) to test whether graduated co-payments ($8 for first visit and $25 for subsequent visits in the same year) discourage non-emergency use of the ER. ($25 exceeds the $8 maximum amount authorized by federal law.) This authority applies to all demonstration populations (newly eligible adults and non-expansion parent/caretakers) and requires a control group of at least 5,000 beneficiaries who are not subject to the increased co-payments.

Appendix Table 3: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved, with pending extension request**
	Pending extension request seeks authority to make the emergency department co-payment policy permanent.
Benefit Packages:	Newly eligible adults 0-138% FPL who pay premiums receive HIP Plus, an ABP that includes the ACA's essential health benefits and covers more services (including vision and dental and more generous prescription drug coverage) than HIP Basic. *Pending extension proposes adding chiropractic benefits to HIP Plus limited to 6 visits per year).* Newly eligible adults at or below 100% FPL who do not pay premiums receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental and less generous prescription drug coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law. Newly eligible adults who are medically frail must have access to the state plan benefit package.[vi] Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance receive the Medicaid state plan benefit package. (Benefit package contents are specified in state plan amendments, not the waiver terms and conditions.) *Pending extension requests waiver of IMD payment exclusion for all beneficiaries ages 21 to 64 to authorize Medicaid payments for short-term stays up to 30 days and would add new SUD treatment services, including expanded inpatient detoxification and peer recovery supports and relapse prevention outpatient services, to benefit packages for all enrollees (cost sharing consistent with eligibility categories)*
Non-Emergency Medical Transportation:	Waives non-emergency medical transportation (NEMT) for newly eligible adults, except pregnant women and those who are medically frail, initially for demonstration year 1 and subsequently extended through year 3. *Pending waiver seeks to extend the NEMT waiver for the duration of the waiver.*
Optional Premium Assistance for ESI:	Newly eligible adults age 21 or older with access to ESI may choose to receive premium assistance and assistance with cost-sharing through a POWER account. The state will fund the POWER account with $4,000 per year for an individual or $8,000 per year for 2 adults in the same household covered by ESI. POWER account funds will be used to pay the state's portion of the ESI premium and contribute to the employee's ESI cost-sharing (deductibles, co-payments, co-insurance). Beneficiaries must contribute to their ESI premium by a payroll deduction of at least $1.00 but not less than 2% of their monthly income. The employer must contribute at least half of the employee's premium, and the ESI benefit package must comply with the requirements for an approved Medicaid ABP. *Extension request seeks to allow all Medicaid eligible family members (spouses and children of HIP 2.0 beneficiaries receiving ESI premium assistance) to receive ESI premium assistance with wrap-around benefits and cost-sharing at state plan amounts. Those who are not eligible for HIP 2.0 would not have POWER accounts.*
SOURCE: Healthy Ind. Plan (HIP 2.0), Special Terms and Conditions, #11-W-00296/5, approved Feb. 1, 2015-Jan. 31, 2018; Ind. Family & Soc. Servs. Admin., Healthy Ind. Plan Section 1115 Waiver Extension Application, submitted Jan. 31, 2017.	

NOTES: i- These include all services rated "A" or "B" by the U.S. Preventive Services Task Force, immunizations recommended by the CDC Advisory Committee on Immunization Practices, and services for infants, children, adolescents, and women supported by HRSA guidelines.
ii- Other qualifying events include obtaining and subsequently losing private coverage, losing income after being disqualified for increased income, residing in a county subject to a disaster declaration within 60 days prior to termination for non-payment, and other circumstances specified by the state.
iii- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.
iv- The debt is limited to the amount of the beneficiary's pro rata share of claims paid during the coverage period or amounts permissible under Medicaid cost-sharing rules for deductibles, whichever is less.
v- Refunds are based on premium payments in excess of the beneficiary's pro rata share of claims at disenrollment.
vi- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.

Appendix Table 4: Iowa's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Iowa Waiver Provision (approved, as amended)**
Overview:	Covers newly eligible adults with incomes up to 138% FPL through Medicaid managed care. Previously used Medicaid funds to pay Marketplace QHP premiums for newly eligible adults from 101-138% FPL statewide under the ACA's Medicaid expansion, but that program was discontinued.
Duration:	12/10/13 to 12/31/19 Eligibility effective 1/1/14
Coverage Groups:	Adults ages 19-64 up to 138% FPL. People who have access to cost-effective ESI are required to receive premium assistance for ESI.
Exempt Populations:	American Indian/Alaska Natives can voluntarily opt into demonstration.
Premiums and Healthy Behavior Incentive Program:	After the first year of enrollment, beneficiaries from 50-100% FPL pay premiums of $5/month. Non-payment of premiums for this group cannot result in disenrollment. Also after the first year of enrollment, beneficiaries from 101-138% FPL pay premiums of $10/month. Beneficiaries have a 90-day grace period to pay past-due premiums in full, after which beneficiaries from 101-138% FPL will be disenrolled. These individuals can re-apply for coverage at any time. Unpaid premiums are considered a collectable debt owed to the state except for those who do not renew coverage and have not received services after the month of the last premium payment. State must waive premiums for beneficiaries who self-attest to financial hardship. Opportunity to self-attest shall be on each premium invoice. Beneficiary premiums waived for the first year of enrollment. In subsequent years, premiums are waived if beneficiaries complete specified healthy behavior activities. In year 1, these include completing an online health risk assessment and obtaining a wellness examination. Beneficiaries have a 30-day grace period in the year in which premiums are due to complete the prior year's healthy behaviors and have premiums waived for the remainder of the year. Beneficiaries who have completed the health risk assessment and wellness exam can then complete specified preventive health-related activities, such as dental exams, smoking cessation, or activities related to diabetes or obesity, to earn financial rewards. Those with income below 50% FPL, those who are medically frail, and American Indians/Alaska Natives are exempt from premiums but still may participate in the healthy behaviors program to earn financial rewards. State submitted for CMS approval a protocol and must document through data and on-going monitoring that enrollees have access to providers in order to apply healthy behavior provisions. Any changes to the healthy behaviors protocol must be approved by CMS.
Co-payments:	Beneficiaries only have co-payments for non-emergency use of the emergency room at state plan amounts. Premiums and co-payments are limited to 5% of quarterly income.
Benefits:	MCOs provide services in the state's Medicaid Alternative Benefits Package (ABP) for newly eligible adults, based on the state employee plan benefits package. Because the new adult ABP is not aligned with the state plan benefit package, medically frail adults must have access to an ABP that includes the full Medicaid state plan benefit package. *Dental:* state provides dental benefits through a capitated commercial dental plan carve-out. Core dental benefits are provided through the ABP. Demonstration provides enhanced dental benefits if beneficiaries complete periodic exam within 6-12 months of first visit and enhanced plus dental benefits if beneficiaries continue periodic exams every 6-12 months. State must assist beneficiaries who timely report that they were unable to obtain a dental appointment and provide access to enhanced benefits for those with a demonstrable need who were unable to access periodic exams. *Non-emergency medical transportation:* state's obligation to provide non-emergency medical transportation for newly eligible beneficiaries (unless medically frail or under age 21) is waived.
Status:	Demonstration approved 12/10/13, amended 12/30/13, 5/1/14, 12/30/14, 7/31/15, 1/1/16, 5/31/16, and 11/23/16.

Appendix Table 4: Iowa's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Iowa Waiver Provision (approved, as amended)**
	Within 6 months of implementation and annually thereafter, state must hold forum for public comment.
SOURCE: Iowa Wellness Plan, Special Terms and Conditions, #11-W-00289/5, approved Jan. 1, 2017-Dec. 31, 2019, amended Nov. 23, 2016.	

Appendix Table 5: Kentucky's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Kentucky Waiver Proposal**
Overview:	Modifies the state's existing Medicaid expansion by: • adding a high-deductible health savings account and an incentive account to existing capitated managed care coverage. Incentive account funds could be used to purchase enhanced benefits. • imposing premiums on most non-disabled adults on a sliding scale from $1 to $15 per month in lieu of copayments. Premiums for those above 100% FPL would be a condition of eligibility and increase beginning in the third year of enrollment. • disenrolling those above 100% FPL for failure to pay a premium after a 60-day grace period and barring re-enrollment for 6 months unless beneficiary pays premiums for grace period and reinstatement month and completes financial or health literacy course. • prohibiting those who do not timely renew Medicaid eligibility from re-enrolling in coverage for 6 months. • requiring work activity hours as a condition of eligibility for most adults. • waiving non-emergency medical transportation for expansion adults. • requiring those with access to cost-effective employer-sponsored insurance to receive premium assistance after the first year of enrollment and employment.
Duration:	Request to implement 6 months following CMS approval for 5 years (plan to implement in the spring of 2017, except that work requirement may be phased in by county or region).
Coverage Groups:	Would include the adult expansion group and all other non-disabled adult Medicaid beneficiaries in most waiver provisions. Would allow CHIP-eligible children to enroll in the same health plan for which their Medicaid-eligible parents are eligible under the waiver. Groups exempt from the waiver include former foster care youth up to age 26; individuals eligible for § 1915(c) home and community-based services waivers; individuals eligible for Medicaid due to a disability, including those with an SSI determination; individuals over age 65; and individuals residing in an institution, such as a nursing facility. Exemptions from specific policies are noted below.
Medical Frailty Determination	Those in hospice, with HIV/AIDS, or receiving SSDI would be automatically considered medically frail. Other individuals could self-identify to their MCO, be identified to the MCO by a provider, or identified by the MCO based on a state-approved health risk assessment and claims data. In all of these cases, the MCO would review and approve the medical frailty designation based on objective criteria established by the state.
Coverage Renewals and Lock-Out:	Would implement an annual open enrollment period for most adults that would vary for each beneficiary depending on when they enrolled in the program (spanning three months prior to Medicaid eligibility expiration and three months following). If beneficiaries fail to renew coverage during this period, they would be required to wait six months before being permitted to re-enroll in coverage, unless the individual completes a financial or health literacy course. Would exempt pregnant women, children, and individuals determined medically frail from this provision.
Premiums:	Would impose sliding scale flat rate monthly premiums for most adults based on family income ranging from $1 for those with incomes under 25% FPL and up to $15 for individuals with incomes from 101-138% FPL in the first two years of enrollment. Premiums would be assessed based on family income rather than per person. Third parties such as non-profit organizations and providers may pay premiums on a beneficiary's behalf. Children and pregnant women would be exempt from premiums. Seeks to impose increasing premiums for individuals with income greater than 100% FPL beginning with a beneficiary's third year of enrollment, which would exceed the premiums that beneficiaries at this income level would face in the Marketplace (2% of income).
Effective Coverage Date:	Seeks to waive retroactive coverage for most adults (except for pregnant women and children) and requires individuals to pay their first month's premium prior to the start of coverage. Individuals below 100% FPL who do not make a premium payment would have coverage start 60 days after they are determined eligible for Medicaid. Those above 100% FPL could not access coverage without a premium payment.

Appendix Table 5: Kentucky's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Kentucky Waiver Proposal**
	The state would develop a process for individuals to make an initial pre-payment to expedite the start of coverage and expand presumptive eligibility sites to include county health departments and certain safety net providers to seek to minimize adverse effects of these waivers.
Disenrollment and Lock-Out for Non-Payment of Premiums:	Premiums are a condition of eligibility for those from 101-138% FPL unless medically frail. This group would be disenrolled from coverage for non-payment after a 60-day grace period and not allowed to re-enroll for six months unless they pay their past debt (2 months of premiums incurred during 60-day grace period); pay the premium for the reinstatement month; and participate in a financial or health literacy course. Individuals below 100% FPL and all those who are medically frail who do not pay premiums would be enrolled in coverage after the 60-day payment period expires and would lose $25 from their incentive account (described below), and the incentive account would be suspended. In addition, those below 100% FPL who are not medically frail must pay state plan copayments for services received during the first 6 months of coverage. They can avoid these penalties before the expiration of 6 months by paying past-due premiums and completing a health or financial literacy course.
Co-Payments:	Beneficiaries who pay premiums would not have any co-payments.
Deductible Accounts:	Would establish an account to which the state would contribute a $1,000 annual deductible that covers non-preventive healthcare services. Once the deductible is exhausted, Medicaid MCOs would cover additional services.
Incentive Accounts:	All adults under the waiver (including pregnant women and those receiving ESI premium assistance) would have an incentive account, which may be used to access additional benefits not otherwise covered, such as dental, vision, over the counter medications, and limited reimbursement for the purchase of a gym membership. Moving vision and dental services from the standard benefit package to the incentive account would be delayed for 3 months after waiver implementation to allow beneficiaries to accrue funds in the incentive account. Enrollees would accrue incentive account funds by transferring 50% of any remaining deductible account funds each year and/or completing specified health-related or community engagement activities, such as participating in community service or job training or a health risk-assessment or passing the GED exam. However, community service or job training activities only qualify for account incentive funds to the extent that those hours exceed the minimum work activity requirement hours (described below). Incentive account funds would be deducted for non-emergency use of the emergency room ($20 for the first visit, $50 for the second visit, and $75 for the third and subsequent visits). Beneficiaries also will be eligible for a $20 incentive account contribution for each year in which they avoid unnecessary emergency room visits. The state may consider a similar program in which incentive account funds could be earned for keeping all appointments in a certain period and would be deducted for missed health care appointments. Former beneficiaries who remain employed and privately insured for 18 months could apply to receive the balance of their incentive account funds in cash, up to $500.
Work Requirement:	Would require all "able-bodied" working age adults to participate in a work activity, such as volunteer work, employment, job search, job training, education, or caring for a non-dependent relative or person with a disabling chronic condition, beginning at 5 hours per week after three months of program enrollment as a condition of eligibility. The work activity requirement would increase up to 20 hours per week after the first year of enrollment. Failure to meet the required work hours would result in suspended benefits until the person complies for a full month. Would exempt children, pregnant women, individuals determined medically frail, students, and individuals who are the primary caregiver of a dependent from this requirement.

Appendix Table 5: Kentucky's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Kentucky Waiver Proposal**
Benefits:	Seeks to waive non-emergency medical transportation for the adult expansion group. Seeks use Medicaid funds to cover out of pocket expenses (test fees) for completion of the GED exam for adults (both expansion and traditional Medicaid populations) without a high school diploma. Seeks to implement pilot program in 10 to 20 counties to obtain federal matching funds for behavioral health services provided in IMDs through a waiver of the federal payment exclusion for non-elderly adults with short-term residential stays up to 30 days. Would use state plan authority to elect the state employee health plan as the benefit benchmark for expansion adults but maintain all current state plan behavioral health services. Children, pregnant women, medically frail individuals, and non-expansion adults (Section 1931 parents) would continue to receive the Medicaid state plan benefit package. The waiver application is unclear about whether the state would continue to cover private duty nursing.[i]
Delivery System:	Would continue to use existing capitated Medicaid managed care organizations for all populations statewide (except those in ESI premium assistance). Seeks waiver authority to eliminate 90-day health plan choice period upon initial MCO enrollment.
Employer-Sponsored Insurance Premium Assistance Program:	Would expand Medicaid premium assistance to include all adults who have access to cost-effective employer-sponsored insurance (ESI). Medicaid and CHIP-eligible children also would enroll in their parent's ESI with premium assistance. Participation would be optional during the first year of Medicaid enrollment, and mandatory after the beneficiary's second year of Medicaid enrollment and employment. Enrollees would receive an advance payment to cover the employee's share of the premium before it is deducted from their paycheck. Enrollees would be subject to the same Medicaid premiums as other adults under the waiver, and the ESI premium reimbursement payment would be reduced by the amount of the beneficiary's Medicaid premium. Individuals would receive Medicaid fee-for-service wrap-around coverage for benefits not covered and all cost-sharing under the employer plan.
Status:	The waiver is pending with CMS and open for a 30-day federal comment period.
SOURCE: Kentucky HEALTH, Pending Application, submitted Aug. 24, 2016.	

NOTES: The waiver application lists private duty nursing as not covered for expansion adults, although the state's response to the public comments indicates that it will not remove private duty nursing from the benefit package, and the application indicates that the private duty nursing cut has been removed from the budget neutrality calculation. Compare page 24, Table 3.2.12(B) with pages 45 and 56 of the Kentucky waiver application submitted to CMS.

Appendix Table 6: Michigan's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Michigan Waiver Provision (approved, as amended on December 17, 2015)**
Overview:	Covers childless adults ages 19 to 64 from 0 to 138% FPL statewide through Medicaid managed care. Requires copayments at state plan amounts for all beneficiaries, which may be reduced by participating in specified healthy behavior activities. Copayments are paid into health savings accounts monthly based on the average copayments for services used in the previous six months. Also requires beneficiaries 100-138% FPL to pay monthly premiums (2% of income) into health savings accounts. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services, for failure to pay copays or premiums. Beginning April 2018, beneficiaries with incomes above 100% FPL who are not medically frail will choose between 2 options: continued coverage through Medicaid managed care or Marketplace QHP coverage with Medicaid premium assistance and cost-sharing subsidies. Those choosing Medicaid managed care must meet a healthy behavior requirement after a one-year grace period.
Duration:	12/30/13 to 12/31/18. Enrollment began 4/1/14.
Coverage Groups:	Adults ages 19-64 up to 138% FPL (childless adults 0-138% FPL, non-working parents from 37-138% FPL, and working parents from 64-138% FPL).[i]
Exempt Populations:	Noncitizens eligible only for emergency services, Program for All-Inclusive Care for the Elderly (PACE) participants, and individuals residing in intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/IDD). As of April 2018, newly eligible adults above 100% FPL who are medically frail will remain in Medicaid managed care and are not subject to being transferred to a Marketplace QHP with Medicaid premium assistance if they do not complete a healthy behavior (described below).
Premiums:	Beneficiaries above 100% FPL pay monthly premiums in the amount of 2% of income after six months of enrollment. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay premiums. This applies to both those in Medicaid managed care and in QHP coverage, when that option becomes available in April 2018. Cost-sharing and premiums cannot exceed 5% of household income.
Co-Payments:	All demonstration beneficiaries have cost-sharing obligations based on their average prior 6 months of copays, billed at the end of each quarter. Cost-sharing is paid into health savings accounts and can be reduced through compliance with healthy behaviors. Amount of cost-sharing is based on state plan amounts and not changed from what would have been collected without the waiver.[ii] Cost-sharing for beneficiaries receiving coverage through Marketplace QHPs, when that option becomes available in April 2018, also will be limited to Medicaid state plan amounts. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays. Copays in excess of 2% of income may be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income. These provisions apply to beneficiaries in Medicaid managed care and those in QHP coverage.
Health Savings Account and Healthy Behavior Protocols:	Health savings account and healthy behavior protocols were developed by the state and approved by CMS. The health savings account protocol describes the online accounts used by beneficiaries enrolled in MCOs and the healthy behavior protocol describes the services beneficiaries can engage in to decrease cost-sharing requirements and how engaging in these activities decreases their required cost-sharing. Changes to the protocols are also subject to CMS approval.[iii] The state must submit a revised healthy behavior protocol to CMS by July 1, 2017 to implement the new healthy behavior requirements for non-medically frail beneficiaries with incomes above 100% FPL as of April 2018; these requirements cannot be more restrictive than those approved in August 2014. These beneficiaries will have a one-year grace period to complete a healthy behavior before they are subject to being moved from Medicaid managed care to Marketplace premium assistance. Enrollees who move from Medicaid managed care to Marketplace premium assistance (for failure to complete a healthy behavior) will be automatically transitioned without additional eligibility determinations. Those who are newly enrolled or whose income increases above 100% FPL in or after April 2018, will have one year of Medicaid managed care coverage to complete a healthy behavior before they are subject to QHP enrollment. By April 1, 2017, the state must submit a transition plan

Appendix Table 6: Michigan's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Michigan Waiver Provision (approved, as amended on December 17, 2015)**
	for how the new waiver provisions will be implemented for beneficiaries above 100% FPL in April 2018.
Delivery Systems and Benefits:	No Medicaid benefits are waived. Medicaid MCOs and PIHPs (for mental health and substance abuse services) are used to serve the newly eligible population. Beneficiaries in Medicaid managed care receive an Alternative Benefits Plan (ABP) that contains the same benefits as the state plan benefit package. Beneficiaries receiving Medicaid premium assistance for Marketplace coverage (beginning in April 2018) will receive an ABP that may be specific to the QHP in which they are enrolled. Michigan will provide wrap-around coverage on a fee-for-service basis for non-emergency medical transportation, EPSDT and family planning services and supplies including access to out-of-network family planning providers for beneficiaries in QHPs. These beneficiaries will also have access to at least one QHP in each service area that contracts with an FQHC/RHC. QHP enrollees may have prescription drug prior authorization requests decided within 72 hours instead of 24 hours, with a 72-hour supply dispensed in an emergency. Those newly determined eligible for waiver coverage will initially be placed in fee-for-service until an MCO is selected or auto-assignment occurs.
Plan Choice and Auto-Assignment:	Enrollment broker assists beneficiaries with MCO selection before relying on auto-assignment. According to the waiver, MCO auto-assignment first takes into account beneficiary's prior or current MCO history and then MCO affiliation of beneficiary's historic providers. In rural counties,[iv] there will only be one MCO. In all other areas, beneficiaries will have a choice of MCOs. There will be one PIHP per region. MCO lock-in for 12 months after initial 90 days to switch plans. The state will develop an auto-assignment methodology for QHP enrollment when that option becomes available in April 2018.
Cost-effectiveness:	Michigan may apply state-developed measures in evaluating the cost-effectiveness of Marketplace premium assistance.
Status:	Demonstration approval 12/30/13, amended 12/17/15, and 6/7/16.
SOURCE: Healthy Michigan Demonstration, Special Terms and Conditions, # 11-W-00245/5, approved Dec. 30, 2013-Dec. 31, 2018, amended Dec. 17, 2015.	

NOTES: i- Childless adults ages 19-64 from 0 to 35% FPL eligible for Michigan's limited benefit package covered by the Adult Benefits Waiver that existed prior to initial implementation of the Healthy Michigan Plan transitioned to full Medicaid coverage as part of the new expansion group.
ii- Beneficiaries are subject to co-pays according to the current state plan (inpatient hospital admission (except emergent admission), $50; non-emergency use of the ER, brand-name drugs, dental visit, or hearing aid, $3; physician, podiatry, or vision office visits, $2; outpatient hospital or chiropractic visit or generic drugs, $1).
iii- Health savings account protocol is Attachment E, and the healthy behaviors protocol is Attachment F of the waiver's Special Terms and Conditions.
iv- Counties considered rural are Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.

Appendix Table 7: Montana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Montana Waiver Provision**
Overview:	Covers approximately 70,000 newly eligible adults through a managed fee-for-service (FFS) Third Party Administrator (TPA). Requires premiums up to 2% of income for newly eligible beneficiaries from 51-138% FPL receiving services through the TPA. Individuals between 101-138% FPL who do not pay their premiums will be dis-enrolled from Medicaid after notice and a 90-day grace period and not allowed to re-enroll until past due premiums are paid or assessed against state income tax refunds by the end of the calendar quarter. Beneficiaries subject to premiums will receive a credit toward accrued co-payments up to 2% of income. The state will implement twelve month continuous eligibility for all newly eligible adults.
Duration:	1/1/16 to 12/31/20, pending state legislative reauthorization of the HELP Program beyond June 30, 2019. If HELP Program is not reauthorized, the state will terminate the waiver.
Coverage Groups:	Covers newly eligible adults ages 19-64 (parents with incomes 50-138% FPL and childless adults with incomes 0-138% FPL).
Exempt Populations:	People with incomes at or below 50% FPL; American Indians/Alaskan Natives; people who have exceptional health needs including but not limited to medical, mental health or developmental conditions (including people who are medically frail); people who live in regions where there are an insufficient number of providers contracted with the TPA; people who require continuity of coverage not available or effectively delivered through the TPA. Individuals exempt from the TPA are also exempt from all demonstration provisions (including premiums) except 12-month continuous eligibility. The waiver application indicated that medically frail beneficiaries will be identified through questions on the Medicaid application and can request an exemption from TPA enrollment at any point thereafter. The 1915(b) selective contracting waiver application also provided that the TPA will refer medically frail individuals that it identifies to the state.
Renewal Simplification:	Twelve month continuous eligibility established for newly eligible adults[i] regardless of the delivery system through which they receive benefits (i.e. even if they are exempt from the TPA).[ii]
Premiums:	Newly eligible adults from 51-138% FPL receiving services through the TPA will pay premiums equal to 2% of household income. Beneficiaries may report changes in income to have premiums re-calculated for the following quarter. Beneficiaries from 101-138% FPL can be dis-enrolled for failure to pay premiums after notice and a 90-day grace period. Re-enrollment when overdue premiums are paid or the state Department of Revenue assesses the premium debt against income tax refunds, no later than the end of the calendar quarter. Re-enrollment shall not require a new application. The state shall establish a process to exempt beneficiaries from dis-enrollment for good cause. Authority to charge premiums is contingent upon the state demonstrating the ability to electronically track out-of-pocket costs quarterly and CMS's approval of the state's preventive services protocol (describing services exempt from co-payments). Third parties are permitted to contribute toward beneficiaries' premium and co-payment obligations.
Co-Payments:	Beneficiaries subject to premiums will receive a credit toward accrued co-payments up to 2% of income. Co-payments will be at state plan amounts with certain services exempt including preventive health care services, immunizations and medically necessary health screenings.[iii] Providers may not deny services for failure to pay copayments for individuals below poverty. All cost-sharing (including premiums and co-payments) is limited to 5% of quarterly household income.
Delivery System and Benefits:	Most newly eligible Medicaid beneficiaries will be enrolled in the TPA. The TPA will be a commercial insurer that already has an established provider network in the state. The state will contract with the TPA to administer the delivery of and payment for services, establish a provider network, reimburse providers on behalf of the state, collect beneficiary premiums, and assume other

Appendix Table 7: Montana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Montana Waiver Provision**
	administrative functions. The TPA is part of the § 1915(b) selective contracting waiver, not the § 1115 waiver. Beneficiaries will receive an ABP benefit package according to a SPA. The ABP for newly eligible individuals enrolled in the TPA will include all services in the Medicaid state plan benefit package except long term care services. Newly eligible adults who are exempt from TPA enrollment will receive an ABP that includes long-term care services through the state's existing fee-for-service system. The Section 1915(b) waiver application provides that certain benefits, such as non-emergency medical transportation and dental services, will be provided outside TPA.
Status:	Demonstration approval 11/2/15 (effective 1/1/16).
SOURCE: Montana Health and Economic Livelihood Partnership (HELP) Program, Special Terms and Conditions, # 11-W-00300/8, approved Jan. 1, 2016-Dec. 31, 2020.	

NOTES: i- Montana is expected to amend its other Section 1115 demonstration waiver to also implement 12-month continuous eligibility for other coverage groups.
ii- Claimed expenditures at the enhanced matching rate will be adjusted downward by 2.6% to account for the fact that the regular matching rate applies to a proportion of expenditures for 12-month continuous eligibility consistent with CMS guidance.
iii- CMS, Special Terms and Conditions, Montana Health and Economic Livelihood Partnership Program Demonstration, Attachment A, Copayment Schedule and Exempt Services (approved Nov. 2, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

Appendix Table 8: New Hampshire's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**New Hampshire Waiver Provision (approved, as amended)**
Overview:	Uses Medicaid funds to pay Marketplace QHP premiums for all newly eligible adults (estimated 50,000) statewide under the ACA's Medicaid expansion as of January 2016. Waiver amendment was approved in January 2017 so beneficiaries above 100% FPL participating in the premium assistance program could be charged different copayments than medically frail beneficiaries above 100% FPL who remain in Medicaid managed care.
Duration:	3/4/15 to 12/31/18. QHP coverage effective 1/1/16. From 8/15/14 to 1/1/16, NH covered expansion adults through a traditional ACA expansion with Medicaid managed care plans.
Coverage Groups:	Newly eligible parents with incomes between 38-138% FPL (non-working) and 47-138% FPL (working) and childless adults ages 19-64 between 0-138% FPL.
Exempt Populations:	People with access to cost-effective employer sponsored coverage and those who are medically frail cannot enroll in QHPs. American Indian/Alaska Natives can opt out of QHP enrollment and receive state plan benefits.
Enrollment:	QHP enrollment is mandatory for demonstration beneficiaries. State provides FFS coverage until QHP enrollment is effective.
QHP Choice and Auto-Assignment:	Beneficiaries will choose between at least 2 silver level QHPs. Beneficiaries who do not select a QHP within 30 days of their Medicaid eligibility determination will be auto-assigned to a plan. The year 1 auto-assignment methodology will take into account factors such as family affiliation, primary care provider affiliation, and premium costs; state must advise CMS 60 days prior to methodology changes.
Retroactive Coverage:	Conditional waiver of three months retroactive coverage, to be implemented after CMS determines that retroactive coverage is unnecessary, based on state data showing no gaps in coverage for newly eligible adults prior to their Medicaid application date and upon renewal.
Premiums:	State pays monthly premiums directly to QHPs. Beneficiaries are not responsible for any premium costs.
Co-payments:	Beneficiaries with incomes below 100% FPL will be enrolled in 100% actuarial value silver plans and have no co-payments. Beneficiaries from 100-138% FPL will be enrolled in 94% actuarial value silver plans and have co-payments at state plan amounts.
Benefits:	QHPs provide services in the state's Medicaid Alternative Benefits Package (ABP) for newly eligible adults.
Federally qualified and rural health centers:	Beneficiaries will have access to at least 1 QHP that contracts with at least 1 FQHC or RHC.
Prescription drugs:	Limited to QHP formulary. Prior authorization within 72 hours instead of 24 hours.
Family planning providers:	State covers out-of-network family planning providers on FFS basis.
Wrap-around benefits:	Provided on FFS basis (non-emergency medical transportation, EPSDT for 19 and 20 year olds, family planning services and supplies, and certain limited adult dental and vision services).
Oversight:	State Medicaid agency will enter into MOU with QHPs regarding enrollment, payment of premiums and cost-sharing reductions, reporting and data requirements, notices, and audits.
Cost-Effectiveness:	May use state-developed tests of cost-effectiveness for premium assistance that differ from those otherwise permissible.
Status:	Demonstration approval 3/4/15, amended 1/6/17.

Appendix Table 8: New Hampshire's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**New Hampshire Waiver Provision (approved, as amended)**
SOURCE: N.H. Health Protection Program Premium Assistance, Special Terms and Conditions, #11-W-00298/1, approved March 4, 2015-Dec. 31, 2018.	